Managing Suicide Risk in BHOP: Recommendations for BHCs

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Suicide in primary care

- Estimated 1-10% of PCC pts experience suicidal sxs
- Of individuals who die by suicide:
  - 45% visit PCP within one month (Luoma, Martin, & Pearson, 2002)
  - 20% visit PCP within 24 hrs (Pirkis & Burgess, 1998)
- Suicidal patients have poorer health and visit medical providers more often (Goldney et al, 2001)
- Medical visits increase in frequency immediately preceding death by suicide (Juurlink et al, 2004)

Confusion abounds…

"When a patient in crisis (i.e., imminently suicidal or homicidal ideation) presents to the primary care clinic, you should make every effort to take this patient off the hands of the PCM and manage the crisis in the primary care clinic. However, since you are not an on-call provider, if you cannot stabilize the patient quickly, use the established system for handling patients in crisis (typically in the specialty mental health clinic). Otherwise, you cannot meet other patient demands and scheduled appointments. You should know and adhere to local policies and procedures for patients who are imminently suicidal or have homicidal ideation. We encourage you to discuss patient-management and admission procedures with the specialty mental health staff. ***NOTE:*** Imminently suicidal patients are, by definition, outside the scope of primary mental health services, and you should recommend to the patient's PCM a referral to specialty mental health. Document your assessment and interventions adequately in the patient's medical record."

BHOP Manual, p. 43

Adaptation is key

Adaptation of empirically-supported, effective strategies for risk assessment and management from specialty MH care and applying it to the BHOP context

Suicide screening

- GPs noted suicide risk in only 3% of patients who died by suicide (Appleby et al, 1996)
- Nonpsychiatric providers less likely to ask about suicide, and pts are less likely to endorse SI (Coombs et al, 1992)
- Suicidal pts much less likely to communicate suicide risk to nonpsychiatric providers than MH providers (Isometsa et al, 1994)
- Only 17% of pts endorsing SI on paper-and-pencil screeners in PCC disclosed SI to PCPs during medical appt (Bryan et al, 2008)

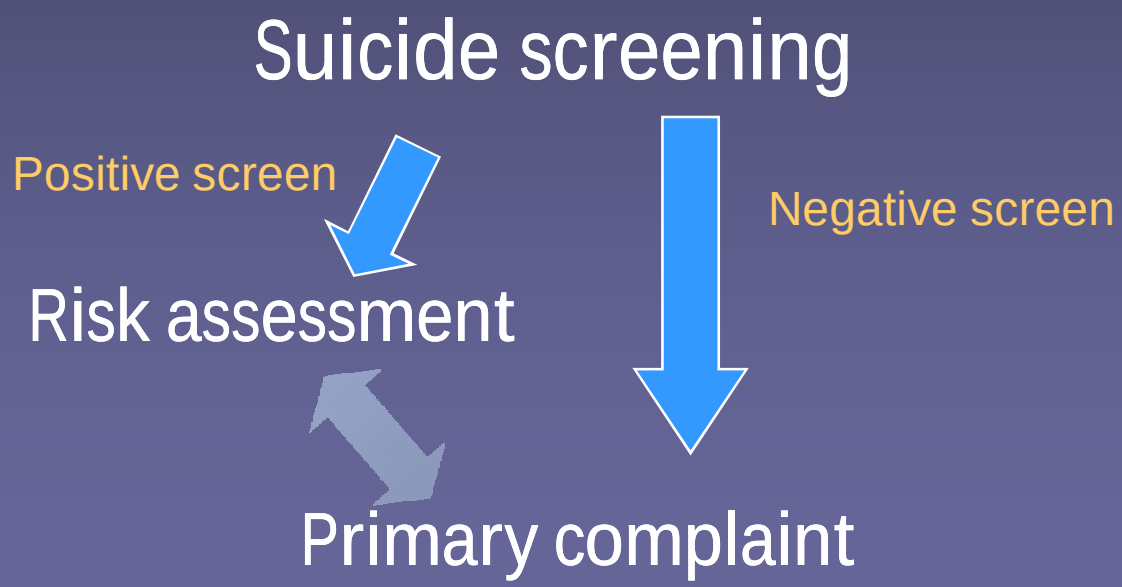
Suicide screening

- Corson et al (2004) found that 6.6% of depressed pts endorsed SI or DI on PHQ-9
  - 35% of positive screens had SI
  - 20% of positive screens had plan
  - "…approximately one-third of the patients who endorsed the PHQ-9 death or suicide item in our study had active suicidal ideation and received urgent clinical attention, which would not have occurred had they not been administered the item addressing thoughts of death or self-harm."
- Currently there is no evidence that routine screening contributes to improved clinical outcomes or reduces suicide attempt or death rates

Two-stage approach

Potential screening methods / devices in PCC:

- PHQ-9
- Behavioral Health Measure-20
- Verbal questioning



Relationship dynamics

- Collaborative stance (Jobes, 2006)
  - Functional analytic approach – what is context of the suicidal crisis and the contingencies that impact it
  - "We're working on this together"
  - Fits well within BHC model of collaborative care
  - Primacy of "bedside manner"
- Confidence and competence
  - Expectancy and confidence in provider increases adherence to recommendations

Competencies

- Understanding suicide
  - Functional model of suicide: attempt to avoid negative or undesirable thoughts / emotions
- Explanatory model of suicide should be simple
  - Easy to explain to pts
  - Easy to explain to PCMs
  - Problem-solving / learning model of suicide

Mechanics

- Maximize information with least amount of variables
  - Multiple attempt status (Clark, Gibbons, Fawcett, & Scheftner, 1989; Forman, Berk, Henriques, Brown, & Beck, 2004; Joiner, Conwell, Fitzpatrick, Witte, Schmidt et al., 2005; Ostamo & Lonnqvist, 2001)
  - Resolved plans and preparation (Beck, Brown, & Steer, 1997; Joiner, Rudd, & Rajab, 1997; Joiner, Steer et al., 2003; Mieczkowski, Sweeney, Haas, & Junker, 1993)
- Sequencing of questions (Shea, 2002)
  - Improved accuracy of disclosure
  - Decreased anxiety during appt

Suggested Sequencing

- Current problem
- Current suicidal ideation
- Screen for multiple attempt status
  - First attempt
  - Worst-point attempt (Brown, Steer, Henriques, & Beck, 2005)
- Current suicidal episode
  - Plans & preparations
- Protective factors

Suicide screening:

- Do things ever get so bad you think about ending your life or suicide?
- Tell me a little bit about what, specifically, you have been thinking. What is it exactly that goes through your mind?

[Differentiate suicidal ideation from nonsuicidal morbid ideation]

If negative suicide screening: Discontinue risk assessment
If positive suicide screening: Screen for multiple attempt status

Multiple attempter screening

- Have you ever had thoughts like this before?
- Have you ever tried to kill yourself before?
- So you've never cut yourself, burned yourself, held a gun to your head, taken more pills than you should, or tried to kill yourself in any other way?

If no evidence of prior attempt(s): Assess current suicidal episode
If positive evidence of prior attempt(s): Assess multiple attempt status

Assess multiple attempt status

- How many times have you tried to kill yourself?
- Let's talk about the first time…
  a. When did this occur?
  b. What did you do?
  c. Where were you when you did this?
  d. Did you hope you would die, or did you hope something else would happen?
  e. Afterwards, were you glad to be alive or disappointed you weren't dead?
- I'd like to talk a bit about the worst time… [Repeat *a* through *e*]

Assess current suicidal episode

- Let's talk about what's going on right now. You said you've been thinking about [content].
- Have you thought about how you might kill yourself?
- When you think about suicide, do the thoughts come and go, or are they so intense you can't think about anything else?
- Have you practiced [method] in any way, or have you done anything to prepare for your death?
- Do you have access to [method]?

Screen for protective factors

- What is keeping you alive right now?

(Bryan, Corso, Neal-Walden, & Rudd, in press)

Functional aspects of suicide

- Distress tolerance & problem solving
  - What is the purpose of the suicidal crisis?
  - "What is the one thing that would make you less suicidal right now?" (Jobes, 2006)
- Emotional avoidance and thought suppression
  - "Is it possible to experience these thoughts and still engage in valued activities?"
- Interventions should target the function & replace suicidal crisis with alternative behaviors that serve the same function

Cognitive-behavioral strategies

- Relaxation / breathing retraining
- Mindfulness / acceptance interventions
- Behavioral activation
- Cognitive restructuring
  - Coping cards
  - Reasons for living cards
- Increased social support
- Physical activity level

Crisis Response Plan

- Problem-solving aid outlining specific steps for patient to follow during periods of crisis (Rudd, Mandrusiak, & Joiner, 2006)
  - Behavioral activation
  - Distress tolerance skills
  - Increased social support

  } Incorporate protective factors
- Written on 3x5 card or behavioral rx pad

Antidepressants

- Decrease in antidepressant rx rates since FDA black box warning (Kurian et al, 2007)
  - "Spillover effect": decrease in pediatric & adult depression dx (Libby et al, 2007; Valuck et al, 2007)
  - 14% increase in adolescent suicide rate (Gibbons et al, 2007)
- Scientific evidence suggests antidepressants actually *decrease* suicide risk (Bostwick, 2006; Gibbons et al., 2007)
- 91% of PCMs give incorrect information about suicide risk among SSRIs to pts (Cordero et al, 2008)
  - PCMs generally overestimate suicide risk

Antidepressant recommendations

- Educate PCMs about black box warning and results of aggregated clinical trials
- Encourage short-term f/u after initiating SSRI
  - Referral to BHC is ideal to supplement med tx with behavioral tx
- Educate PCMs about sxs most strongly associated with increased risk (Rihmer & Akiskal, 2005)
  - Racing / crowded thoughts
  - Physiological agitation
  - Restlessness

Summary

- Primary care is a potentially key area to identify and prevent suicide
  - Integration of MH into primary care is practical and effective approach
- Adaptation to context of primary care is key
  - Integration of MH providers into primary care within BHC model can circumvent barriers
  - Risk assessment and management interventions can be completed efficiently and effectively